

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00542

100

Reg. Dist. No.....

546

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		STATE <u>Md.</u> COUNTY <u>Charles</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		TOWN <u>F.</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (if rural give location)		1 <u>Route 2 Box 118</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pres. Mem. Hosp.</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>JAMES A. ARNISON</u>				<u>Jan 7 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-18-88</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Peeco Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolph Arnison</u>				14. MOTHER'S MAIDEN NAME <u>Emma Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT & ADDRESS <u>Emma L. Birchhead - sister</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cong. St. Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-5-57</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-5-57</u> , to <u>1-7-57</u> , that I last saw the deceased alive on <u>1-7-57</u> , and that death occurred at <u>10:23</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>LaPlata Md.</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>JAN 11 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 11 1957</u>		REGISTRAR'S SIGNATURE <u>Julia Posey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		ADDRESS <u>Wash, D.C.</u>	

CERTIFICATE OF DEATH

RECEIVED
JAN 11 1957
BUREAU V. S.

REGISTERED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00543

1. PLACE OF DEATH a. COUNTY CHARLES 547 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYANTOWN		c. LENGTH OF STAY IN 1b 1 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYANTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL			d. STREET ADDRESS None - Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last BUTLER			4. DATE OF DEATH Month 1 - Day 26 Year 19 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-20		9. AGE (In years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME James A. Butler Sr.			14. MOTHER'S MAIDEN NAME Mary Tolson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212 24 2672		17. INFORMANT WIFE Address MRS JAMES BUTLER - BRYANTOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARBON MONOXIDE POISONING 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE Alcoholism.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overcome by Smoke-Conflagration in home			
20c. TIME OF INJURY Month, Day, Year 3 1-26 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) BRYANTOWN-PHAS MD		20g. (County) CHARLES		20h. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE Russell S. Fisher M.D.			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/27/57
EXAMINER'S NAME (Type) Russell S. FISHER			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-57		22c. NAME OF CEMETERY OR CREMATORY St Mary's Cem	
22d. LOCATION (City, town, or county) Bryantown MD		22e. (State) MD		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE Harold Funeral Home			ADDRESS Waldorf, Mo.		24. REGISTRY BY REGISTRAR Julius R. Rupp

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be added to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 29 1957
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

548

CERTIFICATE OF DEATH

00544

Reg. Dist. No. 100

1. PLACE OF DEATH <i>Charles County</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Spartanburg</i>		MIDDLE		STATE		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Call</i> (First) <i>MARION</i> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>12-57</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>4-21-06</i>	9. AGE last birthday <i>51</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Charles Co mcd.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>THOMAS COLE</i>				14. MOTHER'S MAIDEN NAME <i>MARY Jenkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>571.0 Pneumonia Gram.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>12-31-56</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Inf. dis.</i>				<i>12-29-56</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-29-56</i> , to <i>1-2-57</i> , that I last saw the deceased alive on <i>1-2-57</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>E. J. Delon</i>		M.D.		ADDRESS (Street, city, town, state) <i>1-2-57</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 4 1957</i>		NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		LOCATION (City, town, or county) (State) <i>New Port mcd.</i>	
24. REC'D BY REGISTRAR <i>Julia H. Posen</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Inc.</i>		ADDRESS <i>Spartanburg mcd.</i>	
DATE <i>1/8/57</i>							

4000 204 XV6

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 10 1957

RECEIVED

SHORT STATION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

549

CERTIFICATE OF DEATH

00545

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spring Hill</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Male</u> <u>Infant</u> <u>Cooksey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 16, 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>January 16, 1957</u>		9. AGE last birthday yrs. <u>1</u> mos. <u>5</u>		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>La Plata, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Rudolph Cooksey</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Ann Ray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Howard Cooksey, Spring Hill, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>776x Prematurity, not consistent with survival (5½ mos.) 1' 5"</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Weight 1 lb, 10 oz.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-16-57</u>, 19<u>57</u>, to <u>1-16-57</u>, 19<u>57</u>, that I last saw the deceased alive on <u>1-16-57</u>, 19<u>57</u>, and that death occurred at <u>4:15 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>John H. Gifford</u>				DATE SIGNED <u>Hughesville, Md. 1-16-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>Dentsville, M.E.</u>		LOCATION (City, town, or county) (State) <u>Spring Hill, Maryland</u>	
24. REC'D BY REGISTRAR <u>1/17/57</u>		REGISTRAR'S SIGNATURE <u>Julius H. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. E. LaPlata</u>			

CERTIFICATE OF DEATH

1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Manner of death
10. Signature of physician
11. Signature of registrar
12. Signature of informant

BUREAU V. 3

JAN 21 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

550

Item 14 Film G209 1-18-57 et

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Wash., D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eldorf				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1606 Mass. Ave., Washington, D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 47X-3			
3. NAME OF DECEASED (Type or print) First Ernest Middle F. Last Downs				4. DATE OF DEATH Month 1 Day 9 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-1896	
9. AGE (in years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Hauler				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Tom Downs				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT Francis W. Downs, 2209 Lakewood St. Suitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William J. Kurz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William J. Kurz, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1-14-57		Arlington National		Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Cochran Inc. La Plata Md				24a. REC'D BY REGISTRAR 1/11/57		24b. REGISTRAR'S SIGNATURE Julius H. Poney	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 15 1957

RECEIVED

551

CERTIFICATE OF DEATH

Reg. Dist. No.

00547
100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hughesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hughesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY LAURA LEE FORD</u>		4. DATE OF DEATH Month Day Year <u>JAN. 18 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>St Marys Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABRAHAM BRISCOE</u>		14. MOTHER'S MAIDEN NAME <u>CHARISSA KNIFER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Husband - Robert Ford Hughesville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Chronic Myocardial Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertension</u> (c) <u>Chronic Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 17, 1955</u> to <u>Jan 18, 1957</u> that I last saw the deceased alive on <u>Jan 18, 1957</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert M. Seron</u> M.D.		ADDRESS (Street, city or town, state) <u>Aquasera Md</u> DATE SIGNED <u>1/18/57</u>	
PHYSICIAN'S NAME (Type) <u>V. M. SERON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1-21-57</u>	<u>St Marys Episcopal Cem.</u>	<u>New Market Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hurst Funeral Home</u>		ADDRESS <u>under</u>	24a. REC'D BY REGISTRAR <u>Jan 21 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>John Long</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO PUBLIC HEALTH DEPARTMENT: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 31 1957
BUREAU V. S.

1

INSTRUCTIONS

TO A CORONER, PHYSICIAN OR HOSPITAL: The law requires that the death certificate be returned within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00548

552 CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - WALDORF</u>		LENGTH OF STAY (in this place) <u>LIFE TIME</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - WALDORF</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY F HAMILTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 12 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>US - W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 19, 1867</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>McDavid</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Ethel Robey White Plains, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive heart failure</u>						<u>24 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic heart disease</u>						<u>4 years.</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August</u> , 19 <u>52</u> , to <u>January</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>57</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Sturuddy</u>		M.D. <u>La Plata, Maryland</u>		ADDRESS (Street, city, town, state) <u>12 Jan 57</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-14-57</u>		NAME OF CEMETERY OR CREMATORY <u>Oakland Cem.</u>		LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Jan 15 1957</u>		REGISTRAR'S SIGNATURE <u>Miss M. L. Monroes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u> ADDRESS <u>Waldorf, Md.</u>			

RECEIVED

JAN 16 1957

BUREAU V. S.

1

INSTRUCTIONS

1

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The death copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00549

55 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>LA PLATA</u>		<u>4 DAYS</u>		TOWN <u>HUGHESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE #5</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Gary</u> (Middle) <u>Keith</u> (Last) <u>LAW</u>				(Month) <u>JANUARY</u> (Day) <u>27</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>Dec. 2 1955</u>	<u>1</u> yrs.	Months <u>1</u>	Days <u>25</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>CHILD</u>		<u>NONE</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Larnie L. Law</u>				14. MOTHER'S MAIDEN NAME <u>Helen M. Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u> (If Yes, give war or dates of service)		<u>NONE</u>		<u>Larnie L. Law</u> <u>Hughesville Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA</u>						<u>5 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CELIAC DISEASE</u>						<u>13 MONTHS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>JANUARY</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JANUARY 27, 1957</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>John N. Griffin M.D.</u>		<u>Jan. 29 1957</u>		<u>St. Josephs</u>		<u>Morganza Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>Julia Posey</u>		<u>Hunt Funeral Home</u>		<u>Waldorf Md.</u>	
DATE <u>JAN 31 1957</u>							

BUREAU

JAN 22 1955

RECEIVED

00550

554 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>LA PLATA</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>LA PLATA</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physicians Memorial Hosp</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Jonah J. NEWTON</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 28 1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>US-W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov 29 1885</i>	9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Mfg.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Jewelry</i>		11. BIRTHPLACE (State or foreign country) <i>MASS.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ALONZO Newton</i>				14. MOTHER'S MAIDEN NAME <i>MIRANDO A. POKTON</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i>		16. SOCIAL SECURITY NO. <i>135 10 6645</i>		17. INFORMANT & ADDRESS <i>BESSIE E. Newton LA PLATA, MD.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardio-respiratory failure</i>						<i>3 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Myocardial infarction</i>						<i>10 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerotic heart disease</i>						<i>3 years</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Tumor of Rt kidney</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1952</i> , to <i>28 Jan, 1957</i> , that I last saw the deceased alive on <i>28 Jan, 1957</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>St. Woodward</i>		M.D. <i>La Plata, Md.</i>		ADDRESS (Street, city, town, state)		DATE SIGNED <i>28 Jan 57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>1-30-57</i>	NAME OF CEMETERY OR CREMATORY <i>MT Rest cem.</i>		LOCATION (City, town, or county) <i>LA PLATA, Md</i>		(State)	
24. REC'D BY REGISTRAR <i>Julia Poy</i>	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt. funeral Home - WASHINGTON, Md.</i>		ADDRESS		
DATE <i>JAN 31 1957</i>							

INSTRUCTIONS

1. A. DURING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The information from copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUNN V. 8

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NVI



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00551

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island, Md.		c. LENGTH OF STAY IN Life c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cobb Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) James Andrew Shymansky, Jr.		4. DATE OF DEATH Month 1 Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1942
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Student	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Andrew Shymansky		14. MOTHER'S MAIDEN NAME Margaret Spalding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. James A. Shymansky		Address Cobb Island	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage 314.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gun shot wound left chest DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun discharged accidentally (his)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 1-4 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River Shore		20f. (City or town) (County) (State) Cobb Island, Charles, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE E. J. Edelen		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		DATE SIGNED 1-5-'57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-57	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost		22d. LOCATION (City, town, or county) (State) Issue Md	
23. FUNERAL DIRECTOR'S SIGNATURE Prehart Inc. To place		24a. REC'D BY REGISTRAR DATE 1/7/57	
24b. REGISTRAR'S SIGNATURE Julia H. Parry			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.
 GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 10 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00552
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>PAUL ADRIAN Sweetney</i>		4. DATE OF DEATH Month <i>1</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1924</i> 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Albert Sweetney</i>		14. MOTHER'S MAIDEN NAME <i>LUSSIE DUCKETT</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>517 0284580</i>	
17. INFORMANT Address <i>Albert Sweetney Bryantown MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exposure</i> 982.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Alcoholism and</i> (c) <i>lying in snow sh. at 10° temp</i> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1-19-57</i> <i>1-19-57</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Chas.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-22-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Bryantown MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Hunt Funeral Home Waldorf MD</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 23 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julia Pascoe</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAKING STATEMENT OF DEATH - JANUARY 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 23 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00553
105

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle E. Last Walker		4. DATE OF DEATH Month 1 Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 17 Hours 17 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter Crosen	
14. MOTHER'S MAIDEN NAME unk		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Calvin L. Walker Address Center St SE Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of Diabetes untreated		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-17-'57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR 21 1957		24b. REGISTRAR'S SIGNATURE M. L. Monroe	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 21 1957

RECEIVED